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IN THE

Supreme Court of the United States

DAVID KING, et al.,

Petitioners,

v.

SYLVIA MATHEWS BURWELL, AS UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES, et al.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF OF AMICI CURIAE HARVARD LAW SCHOOL CENTER FOR HEALTH LAW AND POLICY INNOVATION, ET AL. IN SUPPORT OF RESPONDENTS

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INTEREST OF AMICI CURIAE[1]

Amici are the Harvard Law School Center for Health Law and Policy Innovation; ADAP Advocacy Association; AID Atlanta, Inc.; AIDS Action Coalition of Huntsville; AIDS Action Committee of Massachusetts; AIDS Alabama; AIDS Foundation of Chicago; AIDS Institute; AIDS Project Los Angeles; AIDS Resource Center of Wisconsin; AIDS Resource Center Ohio; AIDS United; American Academy of HIV Medicine; Association of Nurses in AIDS Care; Caracole, Inc.; Cascade AIDS Project; Center for HIV Law and Policy; Christie's Place; Colorado Organizations Responding to AIDS; Community Access National Network; Community Catalyst; Duke AIDS/HIV and Cancer Legal Project; Equality New Mexico; Gay Men's Health Crisis; God's Love We Deliver; Health-HIV; HIV Medicine Association; Illinois Coalition for Immigrant and Refugee Rights; Justice Resource Institute; Legacy Community Health Services; Lifelong; Los Angeles LGBT Center; Michigan Consumers for Healthcare; Nashville CARES; National Alliance of State and Territorial AIDS Directors; New Hampshire Voices for Health; NJ For Health Care; NO/AIDS Task Force; North Carolina AIDS Action Network; Ohio Public Health Association; Positive Women's Network Colorado; Pozitively Healthy Coalition; Project Inform; Southern HIV/AIDS Strategy

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[1] By letters on file with the Clerk, all parties have consented to the filing of this brief. Pursuant to Supreme Court Rule 37.6, amici state that no counsel for a party authored this brief in whole or in part; no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief; and no person—other than amici, their members, or their counsel—made such a monetary contribution.

Initiative; UHCAN Ohio; Whitman-Walker Health; and Women's Collective.

While each amicus has its own particular mission, they collectively serve populations that are deeply affected by the availability of federal subsidies under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). Several amici are dedicated to addressing the needs and interests of people living with HIV and AIDS, and all amici have can speak to the harmful consequences that would result from a reversal in this case.

Amici write: (1) to demonstrate that Congress's provision in the ACA of federal subsidies to people who have gained access to insurance on the federal exchanges accomplishes Congress's goal of achieving near-universal coverage and improving the Nation's health; (2) to explain the harms—to vulnerable populations, middle- and low-income households, and higher-earning households alike—that Petitioners' erroneous interpretation of the ACA would cause; and (3) to explain the negative effect that Petitioners' proposed interpretation of the ACA would have on the national ability to respond to public health threats, such as the HIV epidemic, the Ebola virus, pandemic flu, or other as-yet unanticipated public health crises.

SUMMARY OF ARGUMENT

One of the central pillars of the ACA is Congress's creation of health insurance exchanges, which expanded access to the private individual health insurance market for households that do not receive employer-sponsored or public health insurance coverage. 42 U.S.C. § 18091(2)(D), (I)-(J). As the Act's structure demonstrates, Congress understood that ensuring na-

tionwide access to affordable health insurance requires eliminating discriminatory practices, mandating coverage to achieve broad insurance risk pools, and extending subsidies to middle- and low-income Americans who cannot afford to purchase coverage on their own. Together, the ACA's insurance market reforms, individual mandate, and subsidies have yielded the Act's core achievement: transforming the private health insurance markets in all 50 States and the District of Columbia such that nearly all Americans now have access to health insurance.

The government persuasively demonstrates, and the court of appeals correctly held, that the language, structure, and purpose of the Act reveal Congress's aim to permit the use of federal subsidies even in States that decline to establish State exchanges. Those arguments will not be repeated here. Amici write to explain that it makes eminent sense that Congress would have provided for such a scenario, and that available data show that the ACA is accomplishing Congress's goal of achieving "near-universal" access to quality health insurance coverage. 42 U.S.C. § 18091(2)(D). Early results include dramatic expansions of health insurance access among middle- and low-income households and significant reforms in the private insurance market that benefit exchange participants of all income levels nationwide. Health insurance plans are now more comprehensive, premium prices have remained stable, and discriminatory insurance coverage practices are prohibited.

Importantly, increased access to health insurance benefits not only the newly insured, but the Nation as a whole, as Congress intended. This brief reports evidence of both types of success. First, Congress's achievement of its goal is reflected in accounts of indi-

viduals and families whose lives are transformed because—through the subsidies available in all States—they can now obtain the health care they need and are less subject to financial insecurity. Second, the ACA's expansion of health insurance access in all States promises to improve the national ability to respond to epidemics and other large-scale public health threats, just as health insurance access improved the ability of States with broad health insurance to combat the HIV epidemic.

The negative results of a reversal in this case go well beyond "adverse policy consequences." Pet. Br. 15. Rather, the evidence shows that Petitioners' proposed interpretation of the ACA would render a significant provision of the Act ineffective in a majority of States. There is no reason to interpret the Act to render the federal exchanges inoperative, depriving millions of people of access to the health insurance on which they now depend, when Congress plainly intended to bring about the very improvements in individual, familial, and national health care that the ACA has provided when interpreted as the Internal Revenue Service and the Fourth Circuit have interpreted it. This Court should affirm the judgment of the court of appeals.

ARGUMENT

REVERSAL OF THE JUDGMENT BELOW WOULD DEPRIVE MILLIONS OF RECENTLY INSURED AMERICANS OF NEW-FOUND ACCESS TO HEALTH INSURANCE, SERIOUSLY THREATEN HEALTH OUTCOMES, AND UNDERMINE THE NATION'S ABILITY TO ADDRESS EPIDEMICS AND OTHER PUBLIC HEALTH THREATS

A. The ACA's Provision Of Federal Subsidies In All States Has Dramatically Improved Health Insurance Access And Is Integral To The Act's Insurance Market Reforms

The ACA's overall impact on the U.S. health care landscape cannot yet be definitively assessed, but the Act has already transformed the private individual health insurance markets nationwide by significantly expanding access among middle- and low-income households and by reforming these markets for all participants. But if individuals and families in 34 States lose access to federal subsidies—as Petitioners would have it—then health insurance would once again become unaffordable for many, and the federal health insurance exchanges would likely collapse. As a result, the individuals and families who have gained so much under the Act would personally suffer the consequences: Millions of middle- and low-income households would lose access to health insurance altogether, and millions more would have to pay significantly higher premiums to maintain coverage.

1. The ACA's subsidies have yielded unprecedented gains in insurance access among middle- and low-income households

Before the ACA's premium subsidies, middle- and low-income Americans had great difficulty obtaining

affordable health insurance coverage. Millions of households could not access affordable health insurance through their employer, were ineligible for Medicaid and Medicare, and were excluded by—or simply could not afford—plans offered on the private individual market. *See* Hall & Lord, *Obamacare: What the Affordable Care Act Means for Patients and Physicians*, BMJ 1, 2 (2014). The 2014 launch of the ACA's health insurance exchanges brought a sea change, as every household with an income between 100 and 400 percent of the Federal Poverty Level (FPL) (between $11,670 and $46,680 for an individual, and between $23,850 and $95,400 for a family of four in 2014) could access comprehensive health insurance, regardless of employment, place of residence, or health status. Notwithstanding a rollout plagued by technical difficulties, 8 million people nationwide enrolled in exchange health plans during the 2014 open enrollment period, with over 6.7 million individuals (85 percent) obtaining access to affordable insurance through subsidies. Jost, *Implementing Health Reform: A Summary Health Insurance Marketplace Enrollment Report*, Health Affairs Blog (May 1, 2014).

The transition from being uninsured or underinsured to being adequately insured with the help of federal subsidies can be life-changing. For example, Phil Sherburne, 43, and his wife Leia Bell, 37, own a small business in Salt Lake City.[2] Because of a preexisting shoulder injury, Mr. Sherburne had been unable to access affordable insurance through the individual mar-

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[2] The personal accounts reported in this brief were obtained through personal interviews conducted by the Harvard Law School Center for Health Law and Policy Innovation and are used with permission of the individuals involved.

ket for himself, his family, or the employees of his small business. Many insurers denied him family and small-group coverage altogether; others only offered plans with prohibitively high premiums. When his family was uninsured, Mr. Sherburne could not obtain treatment for his injured shoulder, Ms. Bell could not obtain diagnostic tests for persistent abdominal pain, and the couple had to pay out-of-pocket for all health care for their three sons, ages 13, 10, and 8.

In 2014, after implementation of the ACA, Mr. Sherburne enrolled his family in a health insurance plan through the federally operated exchange in Utah. Mr. Sherburne and Ms. Bell were eligible for subsidies because their projected income was $40,000, or less than 150 percent FPL. With subsidies, the entire family was covered for a premium of just $123 per month; without subsidies, the monthly premium would have been $850. Immediately after becoming insured through the ACA, Mr. Sherburne received his first physical examination in over a decade, visited a dermatologist for cancer screening, and obtained physical therapy that improved his shoulder injury and, his doctor believes, likely eliminated the need for future surgery. Once she became insured, Ms. Bell was able to see a doctor about her abdominal pain and, as a result, received surgery to remove her gallbladder just three days later. The surgery was successful; for the first time in her adult life, Ms. Bell no longer suffers from chronic pain. Mr. Sherburne and Ms. Bell also no longer have to pay out-of-pocket health expenses for their three children. When their son recently broke his thumb, his emergency care and cast were both covered.

Mr. Sherburne and Ms. Bell renewed their health insurance plan on Utah's federal exchange for 2015, and their premium payments remain a low $174, com-

pared to the $805 they would have to pay without subsidies. Without access to their $631 monthly subsidy, Mr. Sherburne and Ms. Bell would be forced to cancel their family's health insurance coverage. Mr. Sherburne and Ms. Bell cannot pay themselves a higher salary without jeopardizing their business; they both drive used cars and have no monthly car payment; their children already wear hand-me-down clothing; and they do not take family vacations. Their budget simply could not accommodate the $9660 annual premium that Petitioners' interpretation of the Act would require them to pay.

Lisa Paterson, 60, who is self-employed and lives in Moab, Utah, likewise could not access or afford comprehensive health insurance on the individual market until the ACA's subsidies made it possible. For four years prior to the ACA, she delayed obtaining the health care she needed because of coverage and cost issues. Ms. Paterson was denied access to comprehensive coverage on the individual market because she suffers from preexisting conditions, including an autoimmune disease, osteoporosis, and a previously torn anterior cruciate ligament. Only by depleting her savings account was she able to purchase a high-deductible catastrophic insurance plan, which had a premium of approximately $330 per month and a $7000 deductible.

In 2014, however, Ms. Paterson signed up for a comprehensive HMO plan through Utah's federally run exchange that, after subsidies, cost her only $16.90 per month. Without the subsidies, Ms. Paterson's monthly premium costs would have been $475.34. In 2014, this comprehensive plan enabled Ms. Paterson to visit her primary care physician four times to monitor her conditions and obtain all recommended preventive care. After a routine mammogram revealed a suspicious mass,

Ms. Paterson received diagnostic testing at a world-renowned cancer institute. During the 2015 open enrollment period, Ms. Paterson purchased a new insurance plan on Utah's federally run exchange and, because she earns less than 133 percent FPL, she now pays just $26.30 for her monthly premium costs, compared to the $501.30 she would have to pay without subsidies. If she loses access to this $475 monthly subsidy, Ms. Paterson's only option for maintaining insurance coverage that costs $6015 annually would be to withdraw funds from her retirement account.

As the 2015 open enrollment period is still underway, complete enrollment data are not yet available. But preliminary data indicate that subsidies will once again enable millions of middle- and low-income Americans to obtain affordable health insurance coverage in States using federal exchanges. HHS, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace 2015 Open Enrollment Period: December Enrollment Report* 23 (Dec. 2014). Accordingly, all indications are that the subsidies will continue to play a critical role in reducing the number of uninsured Americans.

2. The subsidies are integral to maintaining insurance market reforms for all exchange participants

The ACA's subsidies are important not only to those who qualify for them, but also to those who do not. Households that do not qualify for subsidies nonetheless benefit substantially from the ACA's reforms to the individual health insurance market, to which the subsidies are integral. Those reforms—which apply to all insureds regardless of whether they receive subsidies—have improved health insurance by ensuring con-

sumer protections, expanding health benefits coverage, and making the individual health insurance market more user-friendly. For many, those reforms have also led to an increase in the number of insurance plan offerings and insurers available.

The ACA's reforms provide that insurers cannot exclude coverage for preexisting conditions, arbitrarily rescind coverage, or base premium rates on an individual's health status. Hall & Lord, *Obamacare* at 3. Plan offerings are also far more comprehensive. Before the ACA, only 2 percent of health plans offered on the individual market covered all ten of the "Essential Health Benefit" categories that the ACA now requires. Boutwell & Freedman, *Coverage Expansion and the Justice-Involved Population: Implications for Plans and Service Connectivity*, 33 Health Affairs 482, 483-484 (2014). Purchasing health insurance on the exchanges is also far easier because insurers are now consolidated into a single marketplace. Further, because insurance plan offerings are now standardized into coverage tiers with defined levels of cost sharing—bronze, silver, gold, and platinum—consumers can more readily compare plans among competing insurers. Hall & Lord, *Obamacare* at 3. For many, the exchanges offer more competitive plan offerings and prices than private insurers offered before the ACA, with new insurers entering the individual markets in response to the opportunity for increased enrollment on the exchanges. *Id.* at 6.

Congress understood, however, that the individual market could not be substantially improved solely through regulation of insurers. 42 U.S.C. § 18091(2)(I)-(J). To ensure that the ACA's insurance regulations do not cause healthy people to defer purchasing insurance until they are sick, Congress established the "individual mandate"—the requirement that every person either

purchase health insurance or pay a tax penalty. 26 U.S.C. § 5000A; *National Fed'n of Indep. Bus.* v. *Sebelius*, 132 S. Ct. 2566, 2577, 2580 (2012) (plurality opinion). Congress also ensured that those who are subject to the individual mandate could afford insurance by providing federal subsidies. 42 U.S.C. §§ 18081-18082; 26 U.S.C. § 36B. Together, the individual mandate and federal subsidies have achieved broad insurance coverage nationwide, enabling insurers to offer the ACA's improved insurance products at affordable premiums. *See* Hall & Lord, *Obamacare* at 6.

The individual mandate and subsidies are interdependent. Congress exempted from the individual mandate households that cannot access affordable health insurance. 26 U.S.C. § 5000A(e)(1)(A). In the absence of federal subsidies, many households in States using federal exchanges would become exempt from the individual mandate because they would no longer have access to affordable insurance. *See* Blumberg et al., *The Implications of a Supreme Court Finding for the Plaintiff in* King v. Burwell 6 (Jan. 2015). Removing the subsidy-eligible population from the exchanges' coverage group would subsequently affect the availability of affordable insurance for higher-earning households. A recent study predicts that eliminating the ACA subsidies would cause a near "death spiral," a cycle of sharp premium increases and subsequent disenrollment until only the sickest individuals remain in the market risk pools. Eibner & Saltzman, *Assessing Alternative Modifications to the Affordable Care Act: Impact on Individual Market Premiums and Insurance Coverage* 25 (2014). A death spiral would result in insurance becoming unaffordable for many higher-earning households, thereby exempting an even greater population from the individual mandate. *See* Hall, *Disingenuous: The Latest Legal Challenges to*

Insurance Market Reforms, 44 Hastings Ctr. Rep. 6, 6-7 (2014). The study demonstrates that subsidies are essential to preserving the economic viability of the ACA's reforms to the individual health insurance market nationwide. Thus, the ACA's subsidies are significant even to those who do not qualify for them because, in the absence of subsidies, many higher-earning households would also lose access to the ACA's improved insurance products.

3. Insurance access gains and market reforms in most States would be lost if the decision below is reversed

Since its full implementation began just one year ago, the ACA has already reduced significantly the number of uninsured American households and transformed the individual health insurance markets in all 50 States and the District of Columbia. Implementation is an ongoing process for the federal government, States, insurers, health care providers, and households nationwide, and promises to continue to improve health care in the United States for years to come, provided the Act's intended scheme remains in place.

However, if households in 34 States lose access to subsidies, then the Act's scheme would collapse in these States, and middle- and low-income households would lose everything they gained under the ACA. *See* Bordelon et al., *The Stage is Set: Predicting State and Federal Reactions to* King v. Burwell 5 (Jan. 2015) (eliminating subsidies would "deliver a crippling blow to the health care law and tarnish much of the implementation progress that has been made to date"). Of the 6.7 million individuals who relied on subsidies to access health insurance during the 2014 enrollment cycle, 4.6 million live in States where federal exchanges operate; most, if not

all, of those people would see their new-found insurance become immediately unaffordable. Levitt & Claxton, *The Potential Side Effects of* Halbig (July 31, 2014); *see also* Blumberg et al., *Characteristics of Those Affected by a Supreme Court Finding for the Plaintiff in* King v. Burwell 7 (Jan. 2015) (predicting that 99 percent of the subsidy-eligible population would face unaffordable premiums following a ruling for Petitioners). These households, including the Sherburne family and Lisa Paterson in Utah, *see supra* pp. 6-9, would be forced to drop coverage immediately or face an average monthly premium increase of $400. *See* Committee on Energy and Commerce, Minority Staff, *District-by-District Impact of a Potential Supreme Court Ruling Against Affordable Care Act Federal Exchange Tax Credits* 1 (Dec. 2014). The millions of affected households could also encounter devastating liability on their 2015 tax return. *See* Grewal, *How* King v. Burwell *May Create Tax Problems for 2014-2015 Health Care Enrollees*, 32 Yale J. on Reg. Online (forthcoming). By 2016, the total number of middle- and low-income Americans denied access to subsidies could reach 13 million. Committee on Energy and Commerce, *District-by-District Impact* at 1.

Petitioners' argument would not only harm middle- and low-income Americans, but also higher-earning Americans who rely on the individual market to access insurance in the affected States. A recent RAND Corporation study predicts that eliminating the ACA subsidies in the 34 States using federal exchanges would result in substantial unsubsidized premium increases and exchange-wide enrollment declines. Saltzman & Eibner, *The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces* 5 (Jan. 2015). This study estimates that, without federal subsidies, *unsubsidized* premiums on the feder-

ally operated exchanges would rise 47 percent, and an estimated 9.6 million people would lose insurance coverage. *Id.* This represents a 70 percent decrease in current federal exchange enrollment and includes higher-earning households as well as subsidy-eligible households. *Id.* The projected premium increases and disenrollment would threaten the ultimate viability of the federal exchanges. *Id.* at 6. Petitioners' argument would thus harm higher-earning Americans who access insurance on the federal exchanges by nearly doubling their premium rates and destabilizing the insurance market on which they rely.

Even if States were to pursue implementing State-based exchanges immediately after losing federal subsidies, that is unlikely to prevent an immediate destabilization of the insurance markets in those States. *See* Bagley et al., *Predicting the Fallout from* King v. Burwell*—Exchanges and the ACA*, 372 New Eng. J. Med. 101 (2015). States would face significant obstacles to establishing State-based exchanges, including the considerable time and resources required, extensive statutory and regulatory requirements, technological challenges, and the timing of State legislative sessions. *Id.* at 101-102. If this Court reverses the court of appeals' judgment, it is highly unlikely that States could establish new State-based exchanges before the vast majority of enrollees were faced with soaring premium costs. *See supra* pp. 12-13. Reversal could therefore prevent millions of Americans from obtaining health insurance for years. *See* Bagley et al., 372 New Eng. J. Med. at 103.

B. Loss Of Affordable Health Insurance Generally Means Worse Health

By increasing access to and improving health care coverage, the ACA's health insurance exchanges have

promoted health outcomes among Americans nationwide. Reversal of the judgment below would not only undermine the Act's statutory scheme, but would also threaten the well-being and longevity of millions of people with serious health care needs.

Having health insurance is associated with improvements in self-reported physical and mental health status and an increased use of preventive care. *See* Van Der Wees et al., *Improvements in Health Status after Massachusetts Health Care Reform*, 91 Milbank Q. 663, 676-678 (2013). Recent studies estimate that expanded access to health insurance decreases annual mortality rates by at least 2.9 percent. *Compare* Sommers et al., *Changes in Mortality After Massachusetts Health Care Reform*, 160 Annals of Internal Med. 585 (2014), *with* Sommers et al., *Mortality and Access to Care among Adults after State Medicaid Expansions*, 367 New Eng. J. Med. 1025 (2012). These findings suggest that, by the end of the open enrollment period in February 2015, at least one death will be prevented for every thousand adults who gained insurance access on the exchanges in 2014. *See* Sommers et al., 160 Annals of Internal Med. at 591; Sommers et al., 367 New Eng. J. Med at 1031. One study estimates that 57 percent of the 8 million people who purchased insurance on the exchanges in 2014 were previously uninsured. Hamel et al., *Survey of Non-Group Health Insurance Enrollees: A First Look At People Buying Their Own Health Insurance Following Implementation of the Affordable Care Act* 6 (2014). Accordingly, this evidence suggests that, after just one enrollment year, expanding coverage through the ACA's health insurance exchanges will have saved thousands of lives.

The positive effect of health insurance on health outcomes is partially explained by the increased access

to, and utilization of, health care services. Adequately insured adults are more likely to receive regular preventive care, which increases the likelihood of timely diagnosis and treatment. McMorrow et al., *Determinants of Receipt of Recommended Preventive Services: Implications for the Affordable Care Act*, 104 Am. J. Pub. Health 2392, 2396-2398 (2014). Preventive care services tend to be low-cost and cost effective; one study estimates that increasing access to preventive care in the U.S. could save nearly $4 billion annually by improving population health and reducing medical spending. Maciosek et al., *Greater Use of Preventive Services in U.S. Health Care Could Save Lives At Little Or No Cost*, 29 Health Affairs 1656, 1658 (2010). Adults with health insurance are also more likely to comply with prescribed treatment regimens and follow-up care, which contribute to better overall health. McMorrow et al., 104 Am. J. Pub. Health at 2396-2398. Most significantly, health insurance saves the lives of people who suffer from conditions that are preventable or treatable if they are identified early, such as certain cancers, infections, and heart disease. *See* Sommers et al., 160 Annals of Internal Med. at 591.

In contrast, uninsured people have greater difficulty obtaining the care they need. In 2013, 25 percent of adults without insurance reported going without care in the previous year, largely due to cost, compared to only 4 percent of adults with coverage. *See* Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer: Key Facts About Health Insurance on the Eve of Health Reform* 6 (2013). Uninsured adults receive significantly less preventive care than adults with health insurance, leading to delayed or forgone treatment, later-stage cancer diagnoses, onset of acute conditions such as heart attack or stroke, and premature

death. Institute of Medicine, *America's Uninsured Crisis: Consequences for Health and Health Care* 68-73 (2009). The uninsured are also more likely to forgo prescribed medications and less likely than insured individuals to obtain all recommended health care services. Cohen et al., *Strategies Used by Adults to Reduce their Prescription Drug Costs*, 119 NCHS Data Brief 1, 1-6 (2013). Overall, a substantial body of evidence shows that uninsured individuals suffer worse health outcomes, including higher mortality rates, because of insufficient access to the health care system. *See* Kaiser Commission on Medicaid and the Uninsured, *Uninsured: A Primer* at 11-12.

The example of Kimberly Tonyan, 42, of Cornelius, North Carolina, illustrates the point. For years as a working single mother, Ms. Tonyan was unable to afford health insurance for herself and her two daughters. Although Ms. Tonyan took her daughters for check-ups, she herself had not received annual exams or screenings, such as physicals or pap smears, for years, because she could not afford them. Although North Carolina has not established its own exchange, in 2014 she was able to sign up for health insurance through a federally run exchange. Due to her income of approximately $20,000, or less than 133 percent FPL, she was eligible for subsidies that brought the cost of her premiums down from $279 to $27.91 per month, saving her $3013.08 in annual premium costs.

A few months later, Ms. Tonyan began experiencing pain in her abdomen. Because she was now insured, she visited a doctor, who diagnosed her with uterine fibroid tumors and an ovarian cyst. After she had a hysterectomy, her doctors discovered that she had endometrial cancer. Luckily, the cancer was caught and removed early, which meant there was no need for

more extensive and expensive treatment, such as chemotherapy or radiation. Moreover, because endometrial cancer is rare in women in their 40s, Ms. Tonyan's doctor recommended genetic testing. This testing revealed that Ms. Tonyan has Cowden syndrome, a genetic condition associated with a greatly increased risk of breast, thyroid, uterine, and kidney cancer. Because she now knows that she has an 85 percent risk of developing breast cancer, Ms. Tonyan chose to have a preventive mastectomy. Ms. Tonyan credits the ACA with saving her life.

Without the subsidies that made it possible for her to purchase insurance on a federally operated exchange in North Carolina, Ms. Tonyan would not have gone to the doctor when she began experiencing pain in her abdomen and might not have sought treatment until the cancer had spread much further. It is also unlikely that she would have sought testing for Cowden syndrome if she lacked comprehensive health insurance, which would have left Ms. Tonyan unaware of her increased risk for breast cancer and unable to pursue the preventive measures she has taken to preserve her health. Because Cowden syndrome is genetic, Ms. Tonyan's diagnosis is also important for preserving the health of her daughters, who can now pursue genetic testing and preventive measures before their health is at risk.[3]

The ACA's health insurance exchanges and subsidies have already improved health and saved lives.

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[3] Because Ms. Tonyan's health issues have affected her ability to work, she now earns less than 100 percent FPL. Accordingly, she did not qualify for a federal subsidy for the 2015 open enrollment period. Since North Carolina opted out of the ACA's Medicaid expansion, Ms. Tonyan is currently without access to affordable health insurance.

Withholding subsidies from the 34 States using federally operated exchanges would threaten the health of the subsidy-eligible population and higher-earning households alike. Some would lose newly acquired coverage that has already dramatically improved their health. Others, who rely on the individual market to purchase insurance, would lose access to care if premium rates spiral and they are priced out of the market. The Court should not construe the Act in a way that would dismantle large portions of the statute and prevent millions of people from obtaining the health care they need and that Congress sought to make available.

C. The Subsidies' Positive Effect On Health Insurance Access Promises To Improve The Nation's Ability To Fight Epidemic Illnesses, Including HIV

Congress's provision for tax subsidies nationwide also promises an additional national impact: improvement of the population's ability to resist epidemic illnesses. The response to the HIV epidemic—which is the subject of extensive data and analysis—has provided a valuable case study for the effect of expanded access to health insurance on the societal ability to address nationwide epidemics—including not only HIV, but future potential epidemics like the Ebola virus or pandemic flu.

1. HIV remains a serious public health threat, and insufficient insurance undermines HIV care and treatment

An estimated 1.2 million people in this country live with HIV, approximately 168,000 people are unaware of their infection, and, with each passing year, about 50,000 people become newly infected. *See* Bradley et

al., *Vital Signs: HIV Diagnosis, Care, and Treatment Among Persons Living with HIV—United States, 2011*, 63 Morbidity & Mortality Wkly. Rep. 1113, 1114 (2014).

It need not be this way. Advancements in medical treatment have vastly improved the length and quality of life for people living with HIV and reduced the likelihood of transmitting the virus to others—but these benefits are only realized by those who can receive sustained clinical care. *See* Goldman et al., *The Prospect of a Generation Free of HIV May Be Within Reach if the Right Policy Decisions Are Made*, 33 Health Affairs 428 (2014). The goal of HIV clinical care is to move patients along a "continuum of care" from infection to diagnosis, engagement in medical care, treatment, and, ultimately, viral suppression. Viral suppression helps people with HIV live longer, healthier lives because suppression preserves the immune system, slows the virus's evolution, and reduces the risk of drug resistance. Cohen et al., *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*, 365 New Eng. J. Med. 493, 503 (2011). Further, at the viral suppression stage, an individual's ability to transmit HIV to others is reduced by 96 percent, significantly slowing the spread of the epidemic. *Id.*

Achieving viral suppression is attainable for the majority of people who receive comprehensive and coordinated care, with recent studies finding that over 80 percent of people living with HIV who receive regular health care are virally suppressed. Mugavero et al., *The State of Engagement in HIV Care in the United States: From Cascade to Continuum to Control*, 57 Clinical Infectious Diseases 1164, 1164 (2013); Bradley et al., 63 Morbidity & Mortality Wkly. Rep. at 1115. Unfortunately, just 25 percent of Americans living with HIV are virally suppressed. Mugavero et al., 57 Clini-

cal Infectious Diseases at 1164. A lack of access to health insurance is strongly associated with this low overall rate of viral suppression, *see id.*, while having health insurance is associated with a 71 percent reduction in mortality among this population, Goldman et al., *Effect of Insurance on Mortality in an HIV-Positive Population in Care*, 96 J. Am. Statistical Ass'n. 883, 888 (2001).

The HIV care necessary to treat the virus and impede its transmission is costly. Comprehensive insurance coverage is accordingly essential to promote individual and public health outcomes and to control—and eventually eliminate—this domestic epidemic. As recently as 2010, only 17 percent of people living with HIV had private health insurance, compared with 65 percent of the American population. Snider et al., *Nearly 60,000 Uninsured and Low-Income People with HIV/AIDS Live in States that are not Expanding Medicaid*, 33 Health Affairs 386, 386 (2014). Before the ACA, many people living with HIV were denied private health insurance due to preexisting conditions, offered prohibitively high premium rates because of their diagnosis, or subjected to annual or lifetime caps on coverage. Kates et al., *Assessing the Impact of the Affordable Care Act on Health Insurance Coverage of People with HIV* 4 (2014).

Some uninsured people living with HIV receive treatment assistance through public programs. For instance, the Ryan White Program, administered by the Department of Health and Human Services as a "payer of last resort," provides limited funding to cities, States, and community-based organizations that offer health care and other services to people living with HIV. Sood et al., *HIV Care Providers Emphasize the Importance of the Ryan White Program for Access to*

and Quality of Care, 33 Health Affairs 394, 394-395 (2014). The Ryan White Program funds State-administered AIDS Drug Assistance Programs (ADAPs), which provide individuals who are uninsured or underinsured with prescription drugs for treating HIV. McManus et al., *Current Challenges to the United States' AIDS Drug Assistance Program and Possible Implications of the Affordable Care Act*, 2013 AIDS Res. & Treatment 1, 1. These programs have never met the needs of all people seeking services; before the ACA, demand for ADAPs ballooned to over 225,000 people living with HIV nationwide. *Id.* at 2. ADAP coverage and eligibility requirements vary widely by State, and many programs have waiting lists for new patients and quantity limits on prescription drug access. *See* Snider et al., 33 Health Affairs at 391.

The Ryan White Program and ADAPs are not designed to function as health insurance plans that provide coverage for a prescribed set of benefits; instead, they focus their limited resources on a core set of HIV services. *See* Snider et al., 33 Health Affairs at 391. People living with HIV have an increased risk and prevalence of comorbidities like cardiovascular disease and diabetes, and many require comprehensive insurance coverage that includes preventive and acute care to improve their health and quality of life. Abara & Heiman, *The Affordable Care Act and Low-Income People Living With HIV: Looking Forward in 2014 and Beyond*, 25 J. Ass'n Nurses in AIDS Care 476, 478 (2014). Coverage through the Ryan White Program and ADAPs simply cannot address these additional health needs.

Again, an example illustrates the point. Tod Haley, 43, of Greensboro, North Carolina, is a loss prevention auditor. Prior to the ACA, Mr. Haley had been unin-

sured since 2007, when his insurer cancelled his health insurance policy after he suffered a herniated disk. In 2008, Mr. Haley, who already could not access insurance because of his preexisting spine injury, was diagnosed with HIV. While he was uninsured, Mr. Haley was able to obtain HIV medications through North Carolina's ADAP. However, Mr. Haley perpetually faced losing access to his life-saving treatment because he had to reapply for ADAP coverage every six months. On several occasions, Mr. Haley was unable to obtain his HIV medications through ADAP because he was waitlisted for coverage. Furthermore, in order to remain eligible for ADAP, Mr. Haley could not earn more than 250 percent FPL. Mr. Haley turned down several employment opportunities in his profession and instead sought minimum-wage positions to ensure that he could continue to obtain his HIV medications.

Because of the ACA, Mr. Haley no longer faces the insecurity of the ADAP renewal process, and he no longer has to choose between advancing his career and receiving his HIV treatment. In 2014, Mr. Haley signed up for health insurance on North Carolina's federally run exchange. During the 2015 open enrollment period, he purchased a new plan offered by Blue Cross Blue Shield. Because of his income of approximately $20,000, or less than 200 percent of FPL, Mr. Haley is now eligible for an ACA subsidy that lowers his monthly premiums to $158 per month from approximately $360. His copayments to see physicians range between $5 and $10, and he pays approximately $15 per month total for his HIV medications. Mr. Haley estimates that his monthly costs for these medications would be approximately $3700 without coverage. Because of his comprehensive coverage, Mr. Haley misses fewer doses of his HIV medications, receives all recommended pre-

ventive care, and obtains ongoing care from a specialist for his herniated disk. If the Fourth Circuit's judgment in this case is overturned, Mr. Haley would lose access to comprehensive health insurance. As a result, he would once again depend on North Carolina's ADAP to access his HIV medications.

People living with HIV who gained comprehensive coverage through the federal exchanges and subsidies in 34 States would suffer disproportionately if they lose health insurance access. Research demonstrates that uninterrupted health insurance is essential to achieving positive health outcomes for people in HIV treatment. Riley, *Population-Level Effects of Uninterrupted Health Insurance On Services Among HIV-Positive Unstably Housed Adults*, 23 AIDS Care 822 (2011). If the decision below is reversed and subsidies become unavailable in a majority of States, people living with HIV who lose access to subsidies or become priced out of failing federal exchanges could suffer harmful treatment disruptions that threaten their lives. These individuals would once again rely on safety-net programs, which were already inadequate before the ACA. Sood et al., 33 Health Affairs at 395.

2. Massachusetts's improvement in HIV health outcomes demonstrates the effectiveness of expanded health insurance coverage in fighting the epidemic

New evidence from Massachusetts demonstrates that expanded health insurance has a proven effect in controlling the HIV epidemic. In 2006, Massachusetts achieved near-universal health insurance coverage by passing a comprehensive health reform law that ex-

panded Medicaid,[4] offered subsidized private insurance, and enacted an individual mandate requiring all Massachusetts residents to purchase health insurance coverage; the Massachusetts statute later served as a model for the ACA. Sommers et al., 160 Annals of Internal Med. at 585; *see also* 42 U.S.C. § 18091(2)(I). Largely as a result of increased coverage, both individual and public health outcomes in Massachusetts are dramatically improved compared to national HIV-related statistics. Harvard Law School Center for Health Law and Policy Innovation, *Massachusetts Case Study: Health Reforms Lead to Improved Individual and Public Health Outcomes and Cost Savings* (June 2012). One study found that, between 2006 and 2009, new HIV diagnoses fell by 25 percent in Massachusetts as compared to a 2 percent *increase* nationwide. *Id.* A more recent study shows that, from 2000 to 2011, the number of HIV-related deaths in Massachusetts declined by 41 percent and the number of HIV infection diagnoses decreased by 44 percent. Harvard Law School Center for Health Law and Policy Innovation, *Massachusetts Case Study: Health Reforms in Conjunction with the Ryan White Program Lead to Improved Individual and Public Health Outcomes and Cost Savings* (May 2014). In contrast, nationwide statistics for HIV-related deaths and new HIV diagnoses remained relatively unchanged. *Id.* People living with HIV in Massachusetts are also far more likely to progress along the HIV continuum of care than people living with HIV nationwide. *Id.*; *see*

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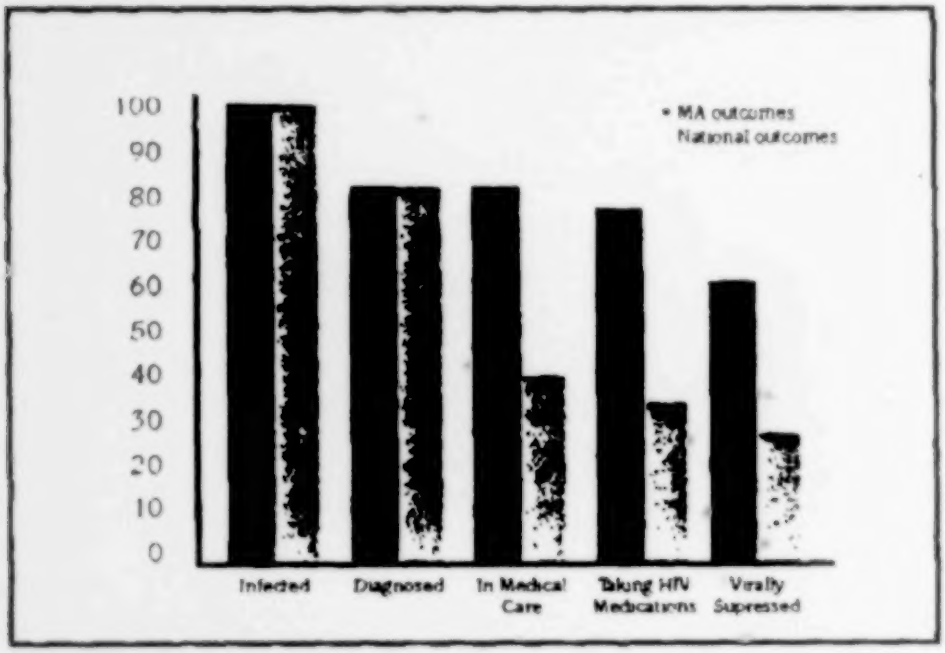
[4] In 2001, Massachusetts expanded Medicaid coverage to pre-disabled people living with HIV whose income was less than 200 percent FPL ($23,340 for an individual in 2014). Bovbjerg & Ullman, *Recent Changes in Health Policy for Low-Income People in Massachusetts*, 17 Urban Institute State Update 1, 14 (2002).

also supra p. 20. The following chart compares the percentages of people living with HIV in Massachusetts who are diagnosed, receive regular medical care, take HIV medications, and are virally suppressed to the percentages of people living with HIV nationwide.

Massachusetts Outcomes vs. National Outcomes[5]



Extending health insurance coverage to people living with HIV has made a measurable difference in Massachusetts's ability to combat the HIV epidemic. Congress's adoption of subsidies and private health insurance reform has created a national capacity to

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[5] This chart, prepared by the Harvard Law School Center for Health Law and Policy Innovation, reports Massachusetts data from Holman et al., *Massachusetts and Southern New Hampshire HIV/AIDS Consumer Study* (June 2011), and national data from Cohen et al., *Vital Signs: HIV Prevention Through Care and Treatment—United States*, 60 Morbidity & Mortality Wkly. Rep. 1618 (2011).

replicate Massachusetts's successes.[6] One study estimates that, by 2017, increased access to preventive care under the ACA will result in an additional 466,153 HIV screenings, leading to 2598 new diagnoses and reducing the number of people who are unaware of their HIV status by 22 percent. Wagner et al., *The Affordable Care Act May Increase the Number of People Getting Tested for HIV By Nearly 500,000 by 2017*, 33 Health Affairs 378, 384 (2014). By making coverage for HIV testing and treatment available, the ACA will ensure that more people living with HIV will be diagnosed, more will discover their status earlier, more will initiate care, and more will achieve viral suppression, *see supra* pp. 20-21, reducing the overall spread of the epidemic.

3. Reversal of the judgment below would undermine the Nation's ability to address future epidemics and other emerging public health threats

The example of HIV demonstrates the important role that expanded health insurance plays in the Nation's ability to resist and fight epidemics and other emerging public health threats. Insufficient insurance access detrimentally affects public health on a societal level because communities nationwide divert resources from public health programs to cover the

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[6] Of course, other factors—such as income levels, baseline insurance access, and number of physicians per capita—will produce *variance* in the rate at which each State will be able to provide treatment to newly insured people living with HIV. *See* Sommers et al., 160 Annals of Internal Med. at 592. Even accounting for such variables, however, the evidence demonstrates that health insurance improves outcomes and reduces the epidemic's spread. *See* Snider et al., 33 Health Affairs at 391.

health care costs of the uninsured. Recent experiences with the Ebola virus exposed the threat that emerging diseases pose to the U.S. public health system, and a recent study found that half of States are unprepared to cope with outbreaks of severe infectious diseases. *See* Levi et al., *Outbreaks: Protecting America From Infectious Diseases* 16 (Dec. 2014) (25 States and the District of Columbia scored five or lower out of ten indicators related to preventing, detecting, diagnosing and responding to serious infectious disease threats). By reducing overall insurance levels, reversal of the judgment below would not only undermine nationwide efforts to eradicate ongoing epidemics like HIV, but also threaten the ability to respond to future public health threats such as pandemic flu, tuberculosis, measles, or bioterrorism.

Prior to the ACA, the Institute of Medicine found that insufficient insurance access had an adverse spillover effect on public health that reached even the insured population. Institute of Medicine, *America's Uninsured Crisis* at 91-95; Institute of Medicine, *A Shared Destiny: Community Effects of Uninsurance* (2003). Insufficient insurance access adversely affected State and local public health programs because they devoted resources to uninsured residents that were reallocated from population-based health programs supporting disease surveillance and community-wide health interventions. Institute of Medicine, *A Shared Destiny* at 144. This diversion of resources weakened the ability of health departments to respond to emerging public health threats and ongoing illnesses like the HIV epidemic. *Id.* at 13. Communities with high rates of uninsured individuals also had insufficient health care delivery capacity, reduced access to emergency medical services, and fewer available clinical specialists. Institute

of Medicine, *America's Uninsured Crisis* at 91-95. Accordingly, the Institute of Medicine recommended that the President work with Congress to achieve health insurance coverage for all Americans "as quickly as possible." *Id.* at 114.

The President and Congress responded with the ACA, which expanded access to the private health insurance market with the help of federal subsidies. A successful response to an infectious disease threat requires that sick people have unimpeded access to the health care system so that infected individuals do not delay seeking treatment, diseases are recognized quickly, and the risk of spreading the disease within the community is minimized. Lurie, *H1N1 Influenza, Public Health Preparedness, and Health Care Reform*, 361 New Eng. J. Med. 843, 844 (2009). By increasing access to routine and emergency medical care, the ACA enables earlier detection, treatment, and control of new diseases. *Id.*; Reeve et al., *The Impacts of the Affordable Care Act on Preparedness Resources and Programs: Workshop Summary* 8-9 (2014).

A successful response to an infectious disease threat also requires community resilience, which is the ability of a healthy community to withstand and recover from a public health emergency. *See* Vinter et al., *Public Health Preparedness in a Reforming Health System*, 4 Harv. L. & Pol'y Rev. 339, 339-340 (2010). Again, Congress improved community resilience through the ACA: Increased health insurance access ensures that individuals regularly receive needed care and reduces population levels of chronic diseases and vaccine-preventable illnesses, so that fewer people will suffer from already compromised health in the event of a public health emergency. Lurie, 361 New Eng. J. Med. at 844; Vintner et al., 4 Harv. L. & Pol'y Rev. at 344.

The availability of subsidies in all States has enabled significant coverage gains among previously uninsured households and improved access to the health care system for all Americans. *See supra* pp. 5-12. As communities become healthier nationwide, the Nation will be better able to cope with ongoing epidemics such as HIV and emerging public health threats such as the Ebola virus or a future flu outbreak. Petitioners' desired toppling of the ACA's statutory scheme in a majority of States, however, would negate all gains in these States and stymie national efforts to promote public health security, threatening the entire population, both insured and uninsured.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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